Enbrel (Etanercept) Prior Authorization Request Form

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To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE Pharmacy Program. Express Scripts is the contractor for DoD.

SPECIAL NOTES: Enbrel and Kineret are non-formulary (Tier 3) under the DoD Uniform Formulary and carry a higher copay for non-Active duty beneficiaries than Humira, Raptiva, and Amevive, which are formulary (Tier 2). TRICARE does not cover Enbrel for Active duty beneficiaries, who pay no co-pay, unless it is determined to be medically necessary instead of a formulary agent.
Medical necessity forms are available on the TRICARE Pharmacy website at http://pec.ha.osd.mil/forms_criteria.php. This form may NOT be used to meet medical necessity requirements. Active duty beneficiaries newly starting on Enbrel or Kineret require both forms.

MAIL ORDER and RETAIL	• The provider may **call**: **1-866-684-4488** or the completed form may be **faxed** to: **1-866-684-4477** • The patient may attach the completed form to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954** or **email** the form only to: TpharmPA@express-scripts.com

Prior authorization criteria and a copy of this form are available at: http://pec.ha.osd.mil/forms_criteria.php. This prior authorization has no expiration date.

Drug for which Prior Authorization is requested: **Enbrel (etanercept)**

Step 1 **Please complete patient and physician information** (Please Print)

Patient Name: _____
Address: _____
_____
Member # _____
Date of Birth:

Physician Name: _____
Address: _____
_____
Phone #: _____
Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. **Is this a continuation of therapy with Enbrel?**	☐ Yes Please sign and date. See quantity limits below.	☐ No Proceed to Question 2
2. **Will the patient be receiving Humira (adalimumab), Kineret (anakinra), or Remicade (infliximab) in combination with etanercept?**	☐ Yes Coverage not approved.	☐ No Proceed to Question 3
3. **Is Enbrel being prescribed for juvenile idiopathic arthritis?**	☐ Yes Please sign and date. See quantity limits below.	☐ No Proceed to Question 4
4. **Is Enbrel being prescribed for the treatment of moderately to severely active rheumatoid arthritis, the treatment of active psoriatic arthritis, or the treatment of ankylosing spondylitis?**	☐ Yes Please sign and date. See quantity limits below.	☐ No Proceed to Question 5
5. **Is Enbrel being prescribed for the treatment of chronic moderate to severe plaque psoriasis for which systemic therapy or phototherapy is indicated?**	☐ Yes Please sign and date. See quantity limits below	☐ No Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ Prescriber Signature

_____ Date

Latest revision: Feb 2008